

# CARE CONNECTION

## PRESENTATION TO NORFOLK CITY COUNCIL

**January 27, 2015**

**Presented by:**

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The Planning Council

# BACKGROUND

- Parenting can be stressful, particularly in the context of unsafe relationships, unstable housing, or physical or behavioral health issues.
- Care Connection is a joint effort of Sentara Norfolk General Hospital and The Planning Council. Other partners include the Virginia Department of Health, the Norfolk Department of Human Services and regional providers of home visiting services.
- Universal screening for newborns is a validated best practice for prevention and early intervention for families who need support, services, resources.
- Universal Screening with referrals to appropriate services began to be explored as a strategy for the Ready By 5 initiative.
- Mayor's Commission on Reducing Poverty identified Universal Screening as a successful strategy to address childhood poverty.

## WHAT IS UNIVERSAL SCREENING?

- A comprehensive and coordinated system of offering help, resources and support to families of all newborns
- Offered to the mother of every newborn
- Provides access to all programs and services

## WHY IS UNIVERSAL SCREENING IMPORTANT TO A COMMUNITY?

- Successful prevention and early intervention strategy
- Addresses identified risks early
- Reduces infant mortality and morbidity
- Provides opportunity for broader community education about safe sleep, access to medical care and immunizations, infant nutrition, child abuse/neglect awareness
- Appropriate early intervention services, such as home visiting, can help reduce the stressors in children's environments that can disrupt brain development

# HOW DOES UNIVERSAL SCREENING WORK?

### Care Connection Screening Process

Sentara nurse prompts questions to every mother. Identified responses fire a Best Practice Alert in the Epic system. The alert goes to the Care Coordination Department at Sentara. Every mother is provided information for Central Intake.

Care Coordinators review the program with the mother and obtain signed consent to release confidential information. Release is faxed to Central Intake at The Planning Council.

Central Intake makes contact with the family within 72 hours and conducts an extensive screening, including a Behavioral Health Risk Assessment. Central Intake collects this data.

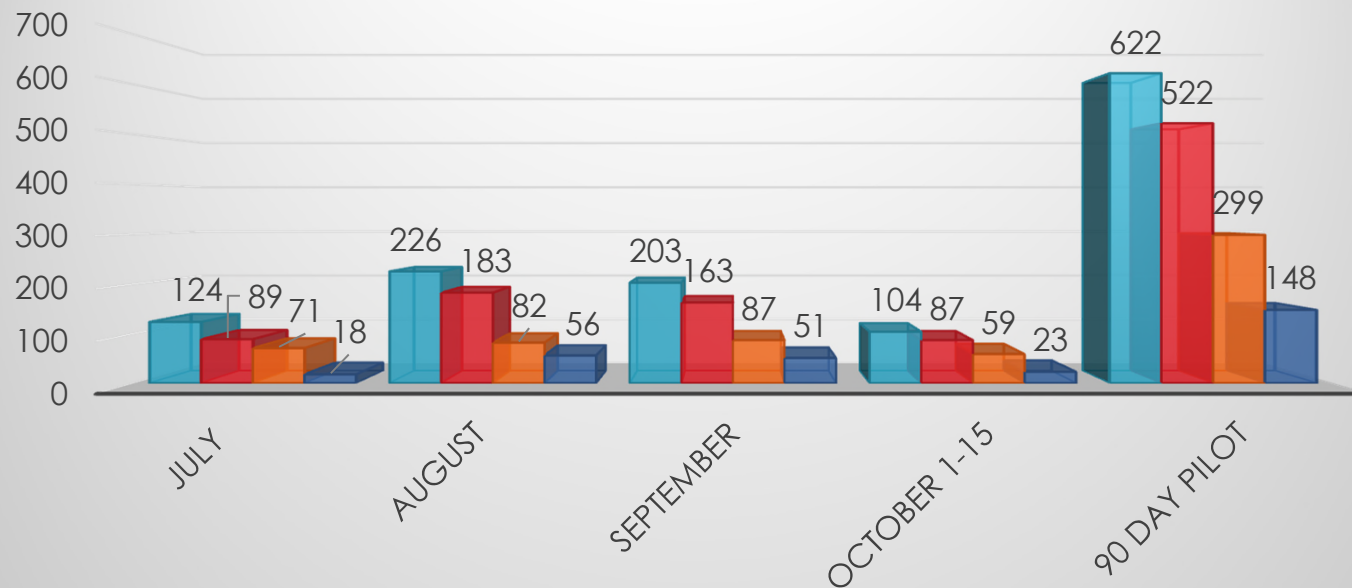
Central Intake makes appropriate referrals to Home Visiting as well as mental health, smoking cessation, substance abuse treatment, and interpersonal violence referrals. Central Intake collects this data.

Central Intake then connects the family with resources for other needs such as food, education, nursing support, clothing, baby basics, support groups, unemployment assistance, and housing assistance.

Central Intake collects dispositions within 90 days of referral.

# Care Connection: SNGH

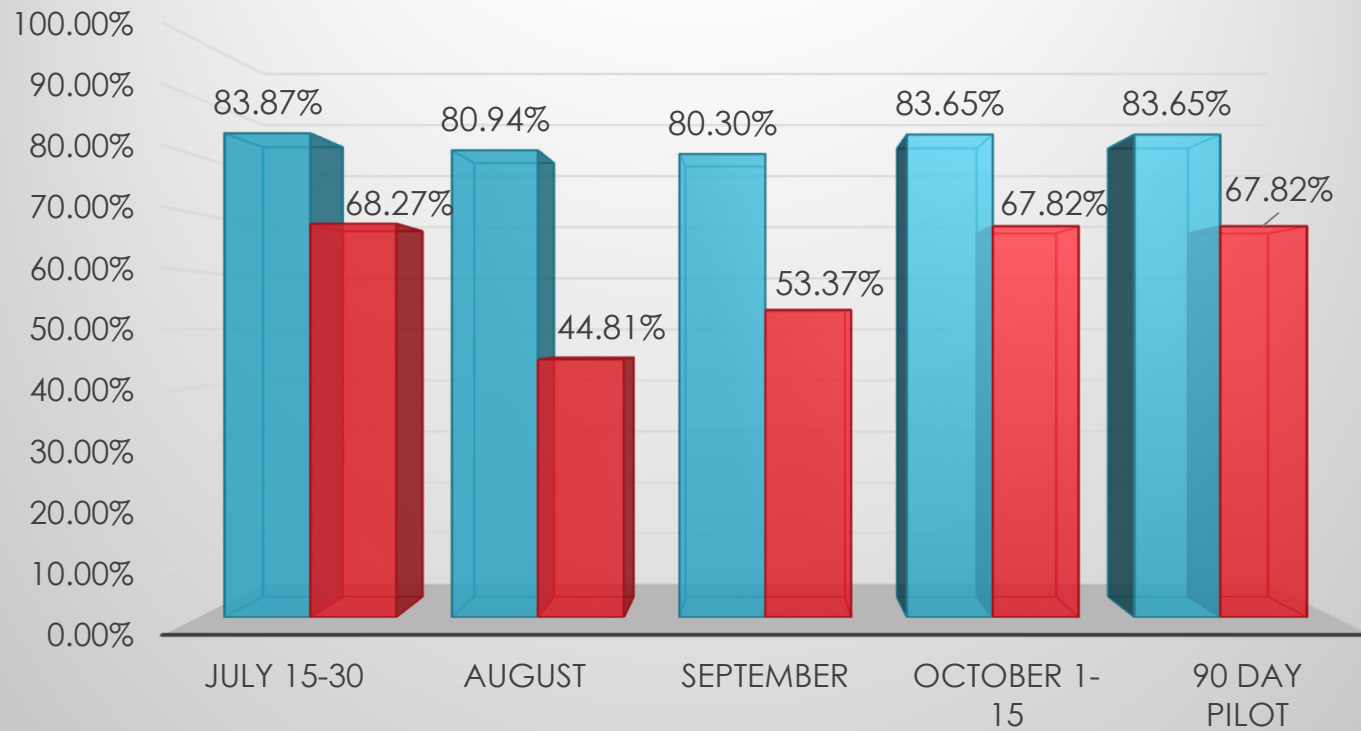
2014



	July	August	September	October 1-15	90 Day Pilot
Total # of Patients	124	226	203	104	622
Qualified	89	183	163	87	522
Accepted	71	82	87	59	299
Declined	18	56	51	23	148

# Care Connection: SNGH

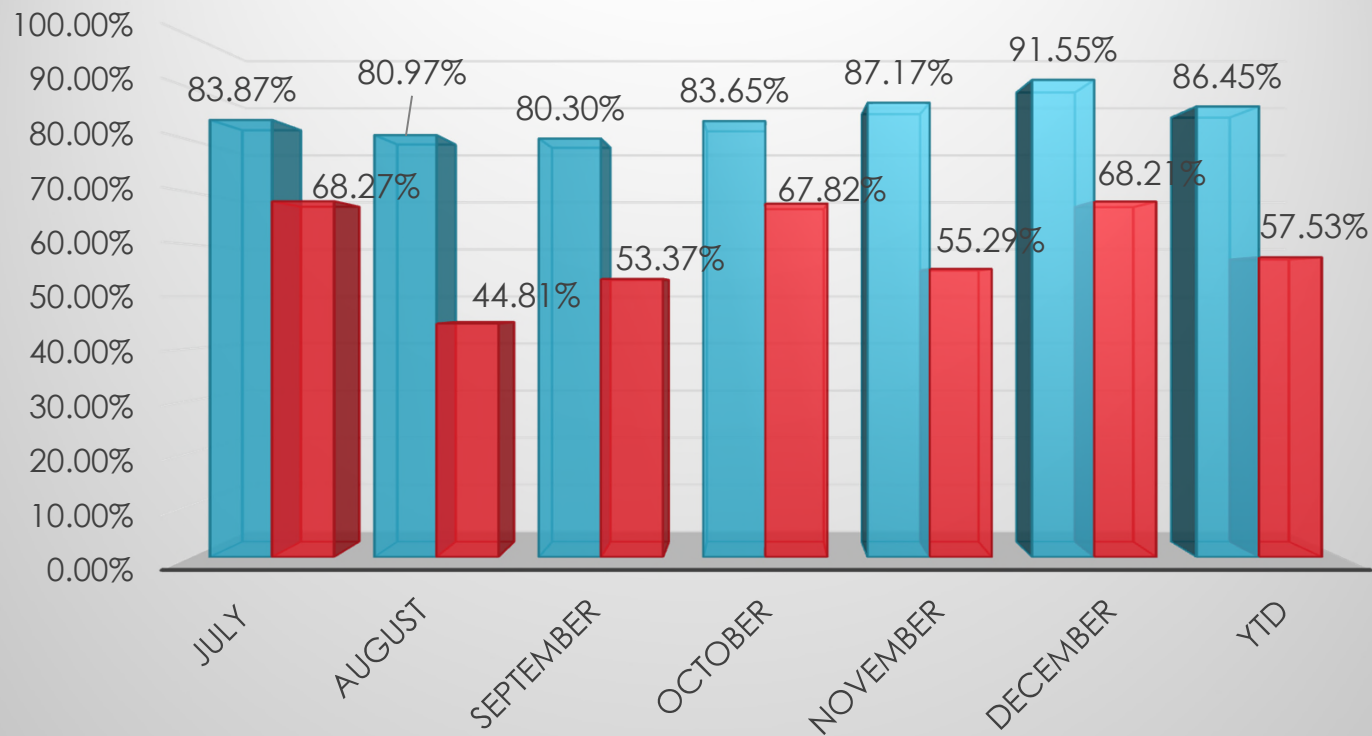
2014



	July 15-30	August	September	October 1-15	90 Day Pilot
Qualified	83.87%	80.94%	80.30%	83.65%	83.65%
Accepted	68.27%	44.81%	53.37%	67.82%	67.82%

# Care Connection: SNGH

2014



	July	August	September	October	November	December	YTD
Qualified	83.87%	80.97%	80.30%	83.65%	87.17%	91.55%	86.45%
Accepted	68.27%	44.81%	53.37%	67.82%	55.29%	68.21%	57.53%



### OUTCOMES

- Every child has a “medical home” – a primary care physician or pediatrician
- Decrease in child abuse/neglect reports related to children screened by Care Connection
- Decrease in foster care placements from families served by Care Connection
- Decrease in infant fatalities due to unsafe sleep practices
- Track longitudinally for increased school readiness

### NEXT STEPS

- ◉ Extend program to other Sentara hospitals
- ◉ Ensure sustainability
  - ◉ Currently funded by \$108,000 grant from the City
    - ◉ Supports 1.5 FTEs (Screening Specialists)
    - ◉ Dedicated portion of grant to go back into the field to build capacity of providers
  - ◉ Funds leveraged from Virginia Department of Health grant support supervision
- ◉ Seek support from hospital foundations
- ◉ Make compelling case for continued City support, in Norfolk and elsewhere
- ◉ Build capacity of home visiting and other prevention/early intervention programs